Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARKRIDGE SURGERY CENTER
190 PARKRIDGE DRIVE
COLUMBIA SC 28289

Respondent Name

TEXAS MUTUAL INSURANCE CO.

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-06-2454-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position Summary was not submitted with request for medical dispute resolution.

Amount in Dispute: $2,392.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester believes it should be paid more based on South Carolina Workers Compensation reimbursement guideline for Ambulatory Surgery Centers (ASC) which is 87.9% of billed charges… It appears the requester is requesting reimbursement based on percentage of billed charges, per the documentation submitted with it dispute (see TWCC-60 packet). The DWC, then the Commission, rejected a percent of billed charges as a valid payment methodology. In the public comments to Rule 134.401 the Commission described its analysis of cost-based models of reimbursement and its reasons for rejecting these with respect to hospital reimbursement, the principal one being that a hospital's costs cannot be verified. And since this is the case with costs then the hospital's charges cannot be a true indicator of facility costs. Given the problems referenced by the DWC in verifying costs in a cost-based system, a hospital could conceivably affect its level of payment without its costs of being verified. And since ultimate reimbursement is dependent on costs there would be little incentive for a hospital to contain or control medical costs. Such problems were enough for the DWC to reject cost-based models of reimbursement as a valid methodology in determining payment for hospitals. TMI asserts the same problem exists in this dispute with the requestor. Because of this TMI argues that the requestor's expectation of payment of its billed amount or a percentage of its billed amount is in appropriate because the cost-to-billed ratio cannot be verified resulting in no incentive to control costs."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2005	Ambulatory Surgical Services	$2,392.37	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. This request for medical fee dispute resolution was received by the Division on November 16, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3)(D), amended to be effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 21, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 10, 2005
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 713 – Fair and reasonable reimbursement for the entire bill is made on the 'O/R service' line item.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided ambulatory surgical services in the state of South Carolina on August 17, 2005 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration on October 18, 2005 requesting the respondent to pay according to the South Carolina Workers Compensation reimbursement guidelines for Ambulatory Surgery Centers and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. In accordance with 28 Texas Administrative Code §133.307(g)(3)(C) the additional documentation shall include a statement of disputed issues that shall include a description of the health care for which payment is in dispute; the requestor's reasoning for why the disputed fees should be paid and how the Texas Labor Code and Division rules, and fee guidelines, impact the disputed fee issues, and how the submitted documentation supports the requestor position for each disputed fee issue. The requestor did not submit additional documentation to support the requestors claim as to why the disputed fee should be paid; how the Texas Labor Code and Division rules and fee guidelines impact the disputed fee issues; or how the submitted documentation supports the their position for each disputed fee issue; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 7, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.